IOWA METHODIST MEDICAL CENTER
Department of Surgery Education
Policies & Procedures

TITLE: Supervision

The Department of Surgery Education affirms that the attending surgeon has both an ethical and a legal responsibility for the overall care of the individual patient, and for the supervision of any residents and medical students involved in the care of that patient. The Department further affirms and recognizes the need for progressive resident autonomy. An institution specific chain of command that acknowledges graded authority and increasing responsibility based upon experience is attached to this policy.

The Department of Surgery Education uses the following classification of supervision: Direct Supervision: The supervising physician is physically present with the resident and patient. Indirect Supervision: The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision or the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. The Department recognizes that supervision can be responsibly provided at any of these three levels depending upon the attending surgeon's judgment based upon his/her direct observation and knowledge of each resident's skills and abilities.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care. The degree of supervision may vary with the clinical circumstances and the training level of the resident, and proper supervision must not conflict with progressively more independent decision making on the part of the resident.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with supervision immediately available. PGY-1 residents must have direct supervision (attending physician) or indirect supervision with attending physician immediately available and direct supervision by a more senior resident during performance of central venous catheterization until the time that the PGY-1 resident has Verification of Proficiency in the procedure by the Program Director.

It is expected that residents under all circumstances will follow the listed chain of command below. Failure to follow the appropriate chain of command will result in disciplinary action consistent with the violation. Similarly, failure of a supervisor to respond appropriately and provide necessary supervision will result in disciplinary action consistent with the occurrence. Invasive procedures may be conducted in an effort to save life or limb while activation of the supervisory notification process is in progress. Such decisions will be reviewed by the Surgery Education Committee and the supervisory faculty retrospectively to determine appropriateness of the action. Inappropriate application of this life and limb saving discretion is subject to disciplinary action. Only designated faculty may supervise residents.

Circumstances and events in which residents must communicate with appropriate supervising faculty member include:

1. Unscheduled advanced imaging studies (CT/MRI)
2. Patient requiring initiation of vasopressor support
3. Procedures (central line, chest tube)
4. Change in level of care (i.e. transfer in/out of ICU)
5. Medical Emergency Team (MET) or Rapid Response Team (RRT) call
6. Patient death
7. End of life discussion
8. Material change in patient condition
9. Resident concern about patient

Supervision in the Department of Surgery Education is consistent with the CIHS-GMEC Policy on Resident Supervision.

ON CALL SUPERVISION

When on call, all patient management problems should be channeled first to the FIRST CALL resident. That resident has the responsibility to assess the problem and relay that assessment to the SECOND CALL resident. While the second call resident may choose to have the first call resident interface with the faculty, the second call has responsibility to notify the senior resident, (i.e. PGY 4 or 5) of any surgical procedure of potential educational value to the senior. The senior resident on call should have knowledge of any surgical procedure prior to initiation whenever possible. The SECOND CALL resident monitors and assists the workload of the FIRST CALL resident. If patient care responsibilities are unusually difficult or prolonged for the FIRST and SECOND CALL residents, the senior resident is available for backup support. Additionally, faculty surgeons are available for any patient care need, regardless of the resident workload.

SUPERVISORY CHAINS OF COMMAND

The supervisory chain of command varies among the institutions of the program, and therefore is established as follows.

IMMC: All Services
Junior Resident (PGY-1, PGY-2, PGY-3)
Senior Resident (PGY-4, PGY-5)
Faculty Attending

BROADLAWNS
Family Practice Resident (PGY-1 & PGY-2)
Surgery Resident PGY-3 or
Surgery Chief Resident
Faculty Attending

VA MEDICAL CENTER
PGY-2 Surgery Resident or
PGY-4 Surgery Resident
Faculty Attending

If the senior resident has concerns about the appropriateness of attending faculty supervision or the quality of the clinical care being provided to the patient, then this concern should be addressed with the Program Director. The Program Director will then work with the attending surgeon or medical staff department chair to resolve the concern.